MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04234

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? one week

Hospital, institution, or street address where death occurred: Wash. Co. Hospital

How long in hospital or institution? one week

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hancock

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Lena Ellen Hill Adams

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Charles Adams

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Febru- 26 - 1917

8. AGE: Years	Months	Days	If less than one day
28	1	15	..... hrs. ..... min.

9. Birthplace: Fulton Co. Penn.

(Town, county, and state)

10. Usual occupation: House wife.

11. Industry or business: Own Home.

FATHER — 12. Name: Joab Hill

FATHER — 13. Birthplace: Fulton Co. Penna

MOTHER — 14. Maiden name: Bertha E. Shaw

MOTHER — 15. Birthplace: Fulton Co. Penna

16. Informant: Mrs. Joab Hill

Address: near Hancock Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 15 1945 (month) (day) (year)

Cemetery or crematory: Rehoboth Cemetery

Location: near Hancock Md.

18. Funeral director: Charles R. Bast

Address: Hancock Md.

19. April 13 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 11, 1945, at 11:45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2, 1945, to April 11, 1945

and that I last saw h.s. alive on April 11, 1945

Immediate cause of death	DURATION
Acute miliary (pulmonic) tuberculosis	2 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Miliary tuberculosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: R. S. Stauffer, M. D. M. D. or other

Address: 170 W. Washington St., Hagerstown, Md Date signed: Apr. 12, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (40)

CERTIFICATE OF DEATH

04235

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: ~~Washington~~

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, institution, or street address where death occurred: 208 Avon Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 208 Avon Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John Hamilton Barnhart

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Ruby Barnhart

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 1884

8. AGE:	Years	Months	Days	If less than one day
	60			hrs. min.

9. Birthplace: Franklin County, Pa. (Town, county, and state)

10. Usual occupation: Concrete worker

11. Industry or business

FATHER 12. Name: George Barnhart

FATHER 13. Birthplace: Franklin County, Pa.

MOTHER 14. Maiden name: -------- Bowders

MOTHER 15. Birthplace: Franklin County, Pa.

18. Informant: Mrs. May Mullenix

Address: 208 Avon Road - Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 16 45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Maryland

19. Funeral director: Fred W. Kraiss

Address: Hagerstown, Md.

19. Apr 15, 1945 (Date rec'd by registrar) Chas H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 13, 1945 at 4:00 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Suffocation by hanging	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Suicide Date of 4/13/45

Where did injury occur? Hagerstown (City or town) Washington (County) Md. (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury: Hung self Injured at work? No

DEPUTY MEDICAL EXAM. WASH. CO., MD.

23. SIGNATURE: A. Robert Wells M. D.

Address: Hagerstown, Md. Date signed 4/14/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician, please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (375)

CERTIFICATE OF DEATH

04236

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Days
Hospital, Institution, or street address where death occurred:
Washington Co. Hospital
How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown,
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 70 Wayside Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Benjamin Albertus Beard

3.(b) Social Security Number: 3I2-I4-7953A

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lila
6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): Oct. 31, 1871

8. AGE: Years	Months	Days	If less than one day
73	3	18	....hrs. ....min.

9. Birthplace: Chewsville Wash. Co. Md.
(Town, county, and state)
10. Usual occupation: Reporter
11. Industry or business: Globe Independent Paper

FATHER
12. Name: John Beard
13. Birthplace: Chewsville, Maryland

MOTHER
14. Maiden name: Sarah Bachtell
15. Birthplace: Chewsville, Maryland.

16. Informant: Mrs. B.A. Beard
Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/21/45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown, Maryland

18. Funeral director: Andrew K. Coffman
Address: Hagerstown, Maryland.

19. Apr. 21 1945 (Date rec'd by registrar) Clark H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19, 1945 at 3 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 3 1941, to Apr 19 1945 and that I last saw him alive on Apr 18 1945

Immediate cause of death: hemorrhage from bladder & prostate — DURATION: 2 days

Due to: benign prostatic hypertrophy — 7 yrs +

Due to:

Other conditions: chronic uremia, hypertension, chr. myocarditis, liver path. prob. amyloid. — 4 yrs +
(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ....Date of.....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. L. Houghton, M.D.
M. D. or other
Address: Hagerstown, Md Date signed Apr 19, 45

Dr. Bell

04237

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

Reg. Dist. No. 602

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 Days
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 8 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Hagerstown County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 122 South Mulberry St
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Edward A. Bostetter

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Cora S.
6.(c) If alive, give age: --

7. Birth date of deceased (mo., day, yr.): November 18 1876

8. AGE: Years	Months	Days	If less than one day
68	5	4	hrs. min.

9. Birthplace: Cearfoss Wash'. Co Md (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Retired

FATHER
12. Name: John Bostetter
13. Birthplace: Hagerstown Md.

MOTHER
14. Maiden name: Ann Johnson
15. Birthplace: Hagerstown Md.

16. Informant: Mrs. Irvin Middlekauff
Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/24/45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown Md.

18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.

19. April 23 1945 (Date rec'd by registrar) Chas H Towers, Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH: April 22 1945 at 4.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1944 to April 22, 1945 and that I last saw him alive on April 22, 1945

Immediate cause of death	DURATION
Chronic glomerular nephritis & uremia.	8 months,
Due to	
Due to	
Other conditions: Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations: No operation — Date of op.
Autopsy results: No autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: R. A. Beel, M. D. or other
Address: Hagerstown Md. Date signed 4/23/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-a)

CERTIFICATE OF DEATH

04238

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 82

Hospital, institution, or street address where death occurred:

512 George Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 512 George Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Harry M. Boward

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Katie Boward

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 28, 1862

8. AGE: Years	Months	Days	If less than one day
82	7	7	..... hrs. ..... min.

9. Birthplace Hagerstown- Wash.- Md. (Town, county, and state)

10. Usual occupation Retired Laborer

11. Industry or business

FATHER 12. Name Hanry Boward

13. Birthplace Hagerstown, Md.

MOTHER 14. Maiden name Sarah Frownfelter

15. Birthplace Wash. Co., Md.

16. Informant W. H. Boward

Address 512 George Street- Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 7, 1945 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Md.

18. Funeral director Fred W. Kraiss

Address Hagersown, Md.

April 7 1945 Chas. H. Boward

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4, 1945 19 8:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 ..... to ..... 19 .....

and that I last saw h..... alive on ..... 19 .....

Immediate cause of death	DURATION
Chronic myocarditis	5yrs
Due to Chr. interstitial nephritis	5yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. Robert Wells DEPUTY MEDICAL EXAMINER WASH. CO., MD. M. D.

Address Hagerstown, Md. Date signed Apr. 6/45

MARGIN RESERVED FOR BINDING

PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94

04239

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 Years

Hospital, institution, or street address where death occurred:

1033 Concord St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1033 Concord Street.

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME: Mrs Virginia Katherine Boward

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Wilbur

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 12, 1899

8. AGE: Years	Months	Days	If less than one day
46	2	15	..... hrs. ..... min.

9. Birthplace: Hagerstown, Wash. Co. Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER
12. Name: Charles Miller
13. Birthplace: Myersville, Md.

MOTHER
14. Maiden name: Mary A. Garrison
15. Birthplace: Charlottesville Va.

16. Informant: Mr. Wilbur Boward

Address: Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 30/45 (month) (day) (year)

Cemetery or crematory: Rest Haven Cemetery

Location: Hagerstown, Md.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown, Md.

19. April 30 1945 Chas H Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 27 1945 at 6.30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I last attended deceased from April 27 1945 to April 27 1945

and that I last saw h... alive on April 27 1945

Immediate cause of death	DURATION
Coronary Thrombosis	1 hr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: D. L. Beachley M. D. or other

Address: Hagerstown, Md. Date signed 4/30/45

VS A15 (T)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Ditto

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 45-f K

04240

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Years
Hospital, Institution, or street address where death occurred:
319 North Cannon Ave
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 319 North Cannon Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Mrs. Eva Grams Boyer

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Charles H.
6.(c) If alive, give age: —
7. Birth date of deceased (mo., day, yr.): July 6 1874

8. AGE: Years	Months	Days	If less than one day
70	9	4	hrs. min.

9. Birthplace: Burkettsville Fred. Co. Md. (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Own Home

FATHER
12. Name: Jonathan Grams
13. Birthplace: Burkettsville Md.

MOTHER
14. Maiden name: Lydia Tritch
15. Birthplace: Burkettsville Md.

16. Informant: Mrs. Eva Smith
Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/12/45 (month) (day) (year)
Cemetery or crematory: Church of God Cemetery
Location: Locust Valley Md.

18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.

19. April 11 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 10 1945 19 at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1-45 19 to April 10-45 19
and that I last saw alive on April 2-45 19

Immediate cause of death	DURATION
Coronary Thrombosis	1 year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. W. Coffman M. D. or other
Address: Hagerstown Md. Date signed: 4/11/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

04241

Reg. Dist. No. 307

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1102 Virginia Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Cora Estella Bryan

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: James W. Bryan
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 24, 1878

8. AGE: Years	Months	Days	If less than one day
66	7	9	..... hrs. ..... min.

9. Birthplace: Franklin County, Penna.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: James Biser
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: James W. Bryan, Husband
Address: Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 15, 1945 (month) (day) (year)
Cemetery or crematory: Rest Haven Cemetery
Location: Hagerstown, Md.
18. Funeral director: Elbert M. Hofner
Address: Hagerstown, Md.

19. April 14 1945 (Date rec'd by registrar) Chas. H. Boward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/13/45 at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 3 1945 to 4/13 1945 and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Pneumonia	4/13/45
Due to: Nephritis, chronic	3
Due to: Arteriosclerosis	?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: H. B. Penfield M.D.
M. D. or other
Address: 136 W Washington Date signed: 4/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

04242

Reg. Diat. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 yrs

Hospital, institution, or street address where death occurred:

60 Blooms ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 60 N. Jonathan St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Theadore Cambell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Married

6.(b) Name of husband or wife: Flora Cambell

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Mar 13 1880

8. AGE: Years	Months	Days	If less than one day
65			..... hrs. ..... min.

9. Birthplace: Stanley Va.

(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Stanley, Va.

FATHER — 12. Name: Henry Cambell

FATHER — 13. Birthplace: ?

MOTHER — 14. Maiden name: Jennie Stribling

MOTHER — 15. Birthplace: Stanley, Va.

16. Informant: Flora Cambell

Address: 60 Blooms ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 21, 45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown Md.

18. Funeral director: William H. Downey

Address: 291 Frederick St.

19. Apr 21, 1945 (Date rec'd by registrar) Blair H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 18, 1945 at 8:40 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec. 6, 1943 to April 18, 1945

and that I last saw him alive on March 27, 1945

Immediate cause of death	DURATION
Pulmonary carcinoma	1 yr.
Due to: Metastasis of primary	
carcinoma of breast	3 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: B B Kuesler M.D. M. D. or other

Address: 148 W. Washington St., Date signed: 4/20/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95d

04243

CERTIFICATE OF DEATH

Reg. Dist. No. 30 21

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 Years.

Hospital, institution, or street address where death occurred: Washington County Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 453 W. Washington St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Lewis G. Colvin

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mollie Colvin

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 1872

8. AGE: Years 73 | Months 1 | Days | If less than one day: hrs. min.

9. Birthplace: Page County, Va. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER 12. Name: Charles Colvin

13. Birthplace: Page County, Va.

MOTHER 14. Maiden name: Sarah McCallister

15. Birthplace: Page County, Va.

16. Informant: Harry Propes

Address: 614 W. Washington Street-Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 24, 1945 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Md.

18. Funeral director: Fred W. Kraiss

Address: Hagerstown, Md.

19. April 24 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 21, 1945 19 8:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 21 19 45 to Apr 21 19 45 and that I last saw h[illegible] alive on April 21 19 45

Immediate cause of death: Myocardial insufficiency ? ?

Due to: Chronic Myocarditis ? ?

Due to:

Other conditions:

DURATION

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: B. Leather M. D. or other

Address: Hagerstown Md Date signed: 4/23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Charles A. Fahrney

Soc. Sec. No. 214-09-5620

John Hamilton Barnhart

Soc Sec No. 217-09-9887

Chas H Boicourt.

Loc Reg. Dist 302

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

T 04244

Reg. Dist. No. 302

1. PLACE OF DEATH: Washington
County
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 weeks
Hospital, Institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 4 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Pennsylvania County Fulton
City or town Hancock, Md. R D 2
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war No

3. (a) FULL NAME: Wilbur Calvin Comerer

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary E. Comerer
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): May 27, 1883

8. AGE: Years	Months	Days	If less than one day
61	11	3	..... hrs. ..... min.

9. Birthplace: Fulton County, Pa. (Town, county, and state)
10. Usual occupation: Farming
11. Industry or business

FATHER
12. Name: John C. Comerer
13. Birthplace: Fulton Co., Pa.

MOTHER
14. Maiden name: Georgia Pittman
15. Birthplace: Fulton Co., Pa.

16. Informant: Mrs. Mary E. Comerer
Address: Hancock, Md. R D 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 3, 1945 (month) (day) (year)
Cemetery or crematory: Damascus Cemetery
Location: Hancock, R F D Fulton Co. Pa.
18. Funeral director: Snyder-Rowland Funeral Home
Address: Hancock, Md.
19. Rec'd May 3, 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April, 30, 1945 at 2:30 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 24 1944 to Apr. 29 1945
and that I last saw him alive on Apr. 29 1945

Immediate cause of death	DURATION
Carcinomatosis	
Due to: Carcinoma of Stomach.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operation
Date of op.
Autopsy results: Destruction of 8th thoracic vertebra
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. Walter Seymour M.D. M. D. or other
Address Hagerstown Md. Date signed 5/4/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (25-C)

CERTIFICATE OF DEATH

04245

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Washington
City or town: Huyett's Crossroads
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Huyett's Crossroads
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R#2 Hagerstown. Md.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Rose Genieve Cook

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: James C. Cook
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 20, 1889

8. AGE: Years	Months	Days	If less than one day
56	0	17	hrs. min.

9. Birthplace: Allegheny Co., Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Frederick Deremer
13. Birthplace: Allegheny Co., Maryland

MOTHER
14. Maiden name: Mary Ann Dawson
15. Birthplace: Allegheny Co., Maryland

16. Informant: James C. Cook
Address: R. R. 2, Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 10, 1945 (month) (day) (year)
Cemetery or crematory: Rest Haven Cemetery
Location: Hagerstown, Md.

18. Funeral director: Elbert M. Hofner
Address: Rest Haven Chapel

19. Apr. 10, 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 7, 1945, at 9:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 22, 1943, to April 7, 1945
and that I last saw her alive on April 7, 1945

Immediate cause of death	DURATION
Aplastic Anaemia. Primary	9 mos.
Due to Rheumatoid Arthritis	5 years.
Due to Rheumatic heart disease	4 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None.
Date of op.
Autopsy results: None.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Arlie Robert Coffman M. D.
Address: Clearspring Md. Date signed: 4/9/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1860

CERTIFICATE OF DEATH

04246

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 56 yrs.

Hospital, Institution, or street address where death occurred:

410 McDowell Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 410 McDowell Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Arthur J. Crum

3. (b) Social Security Number 213 / 06 / 0537

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 9, 1888

8. AGE: Years 57 | Months 3 | Days 12 | If less than one day ..... hrs. ..... min.

9. Birthplace: Fiddlersburg- Wash. Co., Md. (Town, county, and state)

10. Usual occupation: Furniture Factory

11. Industry or business: Employee

FATHER 12. Name: George Crum

13. Birthplace: Wash. Co., Md.

MOTHER 14. Maiden name: Minnie E. Lydia

15. Birthplace: Wash. Co., Md.

16. Informant: Mrs. Bessie Snyder

Address: 410 McDowell Ave- Hagerstown, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 24 1945 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Maryland.

18. Funeral director: Fred W. Kraiss

Address: Hagerstown, Md.

19. April 24 1945 (Date rec'd by registrar) Apr. 24 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 21, 1945 19..... at 6:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Due to	
Due to: Fractured Skull	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: NO

Date of op.

Autopsy results: NO

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: April 21/45

Where did injury occur? Hagerstown (City or town) Wash. (County) Md. (State)

Injured at home, farm, industry, public place (where?): home

Means of injury: Fell down steps Injured at work? no

23. SIGNATURE: J. Rubin Wells DEPUTY MEDICAL EXAM. WASH. CO., MD. M. D.

Address: Hagerstown, Md. Date signed: 4/23/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (D)

04247

CERTIFICATE OF DEATH

Reg. Diat. No. 301

1. PLACE OF DEATH:
County Washington
City or town Williamsport Md R.F.D.#1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Williamsport R.F.D.#1
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Emmert Delauter

3.(b) Social Security Number 214-09-1155

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Buleah Snyder
6.(c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Jan 12 1884

8. AGE: Years	Months	Days	If less than one day
61	2	29	hrs. min.

9. Birthplace Fredrick Co Md (town, county, and state)
10. Usual occupation Laborer
11. Industry or business Bester Long construction
FATHER 12. Name David H. Delauter
13. Birthplace Fredrick Co. Maryland
MOTHER 14. Maiden name Lousia Hoover
15. Birthplace Fredrick Co. Maryland
16. Informant Buleah S. Delauter
Address Williamsport Md. R.F.D.#1
17. burial (Burial, cremation, or removal. Which?) Date thereof April 13 1945 (month) (day) (year)
Cemetery or crematory Manor Cem
Location Near Tilghmaton Md
18. Funeral director Edith V. Leaf
Address Williamsport Md
19. April 13 1945 (Date rec'd by registrar) Mrs E Lee McElroy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1945, at 1.40 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 1945 to April 8 1945 and that I last saw h[illegible] alive on April 7 1945

Immediate cause of death	DURATION
Myocarditis Chronic	1 3 mos.
Due to	
Due to	
Other conditions Arteriosclerosis	3 mos

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [illegible] M.D. or other
Address Williamsport Md Date signed 4/10/45

VS A15 (T)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctage is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK (T) Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04248

Reg. Dist. No. 202

1. PLACE OF DEATH:

County: ~~Washington~~ LIMITS

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 years

Hospital, institution, or street address where death occurred: Washington County Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1101 Corbett Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Minnie M Dulebaum

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	~~White~~ M.

6.(b) Name of husband or wife: Abraham Dulebaum

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 10, 1878

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
67	1	8		

9. Birthplace: Windsor, Maryland (Town, county, and state)

10. Usual occupation: Home Duties

11. Industry or business

FATHER — 12. Name: Melvin T. Berry

FATHER — 13. Birthplace: ---------- Maryland

MOTHER — 14. Maiden name: Jennie Iser

MOTHER — 15. Birthplace: ---------- Maryland

16. Informant: Mrs. Alphonsie Holsinger

Address: 1101 Corbett St.- Hagerstown, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 21 1945 (month) (day) (year)

Cemetery or crematory: Macedonia Cemetery

Location: Near Upton, Pa.

18. Funeral director: Fred W. Kraiss

Address: Hagerstown, Md.

19. Apr. 26 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 18, 1945 at 1:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 28 1944, to April 18 1945 and that I last saw her alive on April 18 1945

Immediate cause of death: Cerebral Hemorrhage — DURATION: apr 15-45

Due to: Hypertensive cardio vascular disease

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Sidney Nowerstein M.D. M. D. or other

Address: Hagerstown Md. Date signed: 4/19/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

04249

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, Institution, or street address where death occurred: 635 Washington Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 635 Washington Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME: Rosalie Elliott

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Paynter F. Elliott
6.(c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) July 31. 1871

8. AGE: Years	Months	Days	If less than one day
73	8	15	....hrs. ....min.

9. Birthplace Princess Ann Somerset Md.
(Town, county, and state)
10. Usual occupation House Wife
11. Industry or business Own Home

FATHER
12. Name Elijah F. Powell
13. Birthplace Princess Ann Md.

MOTHER
14. Maiden name Sallie Pusey
15. Birthplace Princess Ann Md.

16. Informant Mr. Paytner F. Elliott
Address Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 19. 1945 (month) (day) (year)
Cemetery or crematory Friendship Church
Location Princess Ann Md.

18. Funeral director Scott F. Minnich & Son
Address Hagerstown Md.

19. April 17 1945 Chas. H. Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1945 at 10 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/14 1945 to 4/16 1945
and that I last saw h[illegible] alive on 4/15 1945

	DURATION
Immediate cause of death: uraemia	2 days
Due to: chronic endocarditis	
Due to: chronic nephritis	
Due to: arterio-sclerosis.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE V. Ann Mueller M. D. or other
Address [illegible] Date signed 4/16 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04250

Reg. Diat. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 years

Hospital, Institution, or street address where death occurred:

127 N. Mulberry Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 127 N. Mulberry Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Charles A. Fahrney

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Nettie Fahrney

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 25, 1881

8. AGE: Years	Months	Days	If less than one day
63	9	19	..... hrs. ..... min.

9. Birthplace: Leitersburg - Wash. - Md.
(Town, county, and state)

10. Usual occupation: Shoe Factory Employee

11. Industry or business

FATHER 12. Name: Jeremiah Fahrney

FATHER 13. Birthplace: ---------- Pennsylvania

MOTHER 14. Maiden name: Clarenda Williams

MOTHER 15. Birthplace: ---------- Pennsylvania

16. Informant: Mrs. Nettie Fahrney

Address: 127 N. Mulberry St- Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 16, 1945 (month) (day) (year)

Cemetery or crematory: Rest Haven Cemetery

Location: Hagerstown

18. Funeral director: Fred W. Kraiss

Address: Hagerstown, Maryland.

19. Apr. 15, 1945 (Date rec'd by registrar) Chas. F. Boward, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 13, 1945, 19..., at 4:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 11, 19 45, to Apr 13, 19 45, and that I last saw h... alive on Apr 13, 19 45

Immediate cause of death	DURATION
Carcinoma of Prostate	1 yr +
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Harold P. Boteler M.D. M. D. or other

Address: Hagerstown Md. Date signed: 4/14/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr. Earl Young

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04251

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 weeks.

Hospital, institution, or street address where death occurred:

Wash. Co. Hospital

How long in hospital or institution? 7 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Boonsboro

(If outside city or town limits, write RURAL and give nearest town)

Street No.: N. Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war: - None. -

3. (a) FULL NAME: W. Rush Flora

3. (b) Social Security Number: 213-16-0995

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Rose Flora

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 19 1880

8. AGE: Years 64 | Months 8 | Days 15 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Boonsboro Washington Co. Md.
(Town, county, and state)

10. Usual occupation: Farmer Employee of P.E.Co.

11. Industry or business: Retired

FATHER
12. Name: Alexander Flora
13. Birthplace: near Smithsburg Md

MOTHER
14. Maiden name: Elizabeth Glenn
15. Birthplace: near Smithsburg Md.

16. Informant: Mrs. Anna Penner

Address: 610 Wash. Ave. Hagerstown Md

17. Burial. (Burial, cremation, or removal. Which?) Date thereof: April 6 1945 (month) (day) (year)

Cemetery or crematory: Boonsboro Cemetery

Location: Boonsboro Md.

18. Funeral director: Wm. D. Bartgis Sons

Address: Boonsboro Md.

19. April 5 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/4/45 19..... at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/29/45 19..... to 4/4/45 19.....

and that I last saw him alive on 4/4/45 19.....

	DURATION
Immediate cause of death: Congestive Heart Failure	24 hrs.
Due to:	
Due to:	
Other conditions: Fract. at humerus & Pathological fracture, secondary to lues? Cancer? O.S.P. (Include pregnancy within 3 months of death)	

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Earl Young M.D.
M. D. or other

Address: ..... Date signed .....

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. wells

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-e

CERTIFICATE OF DEATH

04252

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Year

Hospital, Institution, or street address where death occurred:

1000 Columbia Road

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1000 Columbia Road

(If rural, give LOCATION)

2.(a) If veteran, name war: --

3. (a) FULL NAME: Judith Fogelgren

3. (b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fenale	white	Single

6.(b) Name of husband or wife: --

6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): October 13 1942

8. AGE: Years	Months	Days	If less than one day
2	6	7	...hrs. ...min.

9. Birthplace: Hagerstown Wash. Co. Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER

12. Name: John E. Foglegren

13. Birthplace: Washington D.C.

MOTHER

14. Maiden name: Marion O. Bonavita

15. Birthplace: Washington D.C.

16. Informant: John E. Foglegren

Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/23/45 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Location: near washington D.C.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19. Apr. 24 1945 (Date rec'd by registrar) Registrar: Clark H Bowers

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20 1945 19..., at 9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...

and that I last saw h...alive on ...19...

Immediate cause of death	DURATION
Open fracture of skull	
(crushed)	
Due to: Shock	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: no

...Date of op.

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of Apr/20/45

Where did injury occur? Hagerstown, Wash., Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Fairfiew Rd.

Means of Injury: Ran over by school bus Injured at work?

DEPUTY MEDICAL EXAM. WASH. CO. MD.

23. SIGNATURE: Robert Wells M. D. or

Address: Hagerstown, Md. Date signed 4/20/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Le Van

(M)

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04253

Reg. Dist. No. 305

1. PLACE OF DEATH:
County Washington
City or town Near Maplesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, Institution, or street address where death occurred: Boonsboro Md. R. 2
How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Washington
City or town Near Maplesville (If outside city or town limits, write RURAL and give nearest town)
Street No. Boonsboro Md. R. D. (If rural, give LOCATION)
2.(a) If veteran, name war - None -

3.(a) FULL NAME John Calvin Ford

3.(b) Social Security Number None

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Orpha Ford
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): December - 1 - 1890
8. AGE: Years 54 | Months 4 | Days 9 | If less than one day ..... hrs. ..... min.
9. Birthplace Near Boonsboro Washington Co. Md. (Town, county, and state)
10. Usual occupation Retired Farmer and
11. Industry or business Fruit Grower
FATHER 12. Name John Ford
FATHER 13. Birthplace Boonsboro Washington Co. Md.
MOTHER 14. Maiden name Emma Horine
MOTHER 15. Birthplace Near Middletown Frederick Co. Md.
16. Informant Mrs. Orpha Ford
Address Boonsboro Md. R. 2
17. Burial - (Burial, cremation, or removal. Which?) Date thereof April 13. 1945 (month) (day) (year)
Cemetery or crematory Boonsboro Cemetery
Location Boonsboro Md.
18. Funeral director Wm. J. Bast & Sons
Address Boonsboro Md.
19. April 13, 1945 (Date rec'd by registrar) John H. Bast Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10, 45 19 ..... at 10 P. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 8 19 45 to April 10 19 45
and that I last saw him alive on April 10 19 45

Immediate cause of death	DURATION
Lobar Pneumonia -	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE G. W. LeVan M. D. (M. D. or other)
Address Boonsboro, Md Date signed 4/12/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04254

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 323 Mitchell Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Susan Ann Fox

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 16, 1945

8. AGE:

Years	Months	Days	If less than one day
0	0	1	hrs. min.

9. Birthplace: Hagerstown, Wash. Co. Md.

(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER

12. Name: Samuel J. Fox

13. Birthplace: Maugansville, Maryland

MOTHER

14. Maiden name: Mary F. Crouse

15. Birthplace: Waynesboro, Pa.

16. Informant: Samuel J. Fox

Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-18-45 (month) (day) (year)

Cemetery or crematory: Rest Haven Cemetery

Location: Hagerstown, Maryland

18. Funeral director: C. M. Suter & Sons

Address: Hagerstown, Maryland

19. April 16 1945 Chas. H. Bowers

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 17 1945 at 6:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 16 1945 to April 17 1945 and that I last saw her alive on April 17 1945

Immediate cause of death	DURATION
Premature infant	
Due to: Respiratory failure	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: H Bortfeld M.D. M. D. or other

Address: 134 W Washington Date signed: 4/18/45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.


RECEIVED
APR 20

Evidence for adding of information is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04255

FILM No. G 95 MAY 22 1945

CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH:
County: Washington
City or town: Rural Clear Spring, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? West
Hospital, Institution, or street address where death occurred: Route 40 Clear Spring Dist.
How long in hospital or Institution?

2. USUAL RESIDENCE: (Where deceased lived. If institution, give last residence of inmate.)
State: Maryland County: Wayne
City or town: Goldsboro (If outside city or town limits, write RURAL and give nearest town)
Street No. 617 Walnut (If rural, give LOCATION)
2.(a) If veteran, name war: World War II

3.(a) FULL NAME: Glenn James Gosnell

3.(b) Social Security Number: 237-26-5534

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Pauline Craddock Gosnell
6.(c) If alive, give age: 19 years

7. Birth date of deceased (mo., day, yr.): June 14, 1918

8. AGE: Years: 26 Months: 10 Days: 5 If less than one day: hrs. min.

9. Birthplace: Marshall County, N.C. (Town, county, and state)
10. Usual occupation: Truck driver
11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Pearl Gosnell
15. Birthplace: North Carolina

16. Informant: Mrs. Glenn J. Gosnell
Address: 617 Walnut St. Goldsboro, N.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 22 1945 (month) (day) (year)
Cemetery or crematory: Willow Dale Cemetery
Location: Goldsboro, N.C.

18. Funeral director: Snyder-Rowland Funeral Home
Address: Clear Spring, Md.

19. April 20 1945 (Date rec'd by registrar) Registrar: Joseph Murray

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19 1945 at 11:40 A.M.

I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Multiple fractures of extremities	
Due to: Crushed skull	
Due to: crushed abdomen	
Other conditions: hemorrhage & shock	

(Include pregnancy within 3 months of death)

Major findings of operations: No
Date of op.
Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 4/20/45
Where did injury occur? Clearspring (City or town) Wash. (County) Md. (State)
Injured at home, farm, industry, public place (where?) US. 40
Means of injury: truck ran off ro Injured at work? Yes

23. SIGNATURE: L. Robert Wells DEPUTY MEDICAL EXAM. WASH. CO., MD. M. D.
Address: Hagerstown, Md. Date signed: 4/20/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04256

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Near Hagerstown Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 years

Hospital, institution, or street address where death occurred:

Near Woodpoint, Route #2

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Near Hagerstown, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Hagerstown, Rt. #2

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: James O. Harvey

3.(b) Social Security Number: 214-09-1346

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary V. Harvey

6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): Sept. 9, 1878

8. AGE:

Years	Months	Days	If less than one day
66	6	26	...hrs. ...min.

9. Birthplace: Phillipi, W. Va. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Baer Brothers

FATHER — 12. Name: John Harvey

FATHER — 13. Birthplace: Phillipi, W. Va.

MOTHER — 14. Maiden name: Minerva J. Nutter

MOTHER — 15. Birthplace: Phillipi, W. Va.

16. Informant: Mrs. James O. Harvey

Address: Near Woodpoint, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-7-45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Maryland

18. Funeral director: C. M. Suter & Sons

Address: Hagerstown, Maryland

19. April 6 19 45 (Date rec'd by registrar) Chas H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/4/45 19... at ...M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/3/45 19... to 4/3/45 19...

and that I last saw him alive on 4/3/45 19...

Immediate cause of death	DURATION
Tobacco Sonamona	3 wks
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ...Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Earl Young M.D. M. D. or other

Address: Date signed:

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04257

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Wash. Co. Hospital

Stay in hospital or inst. (yrs., or mos., or days): One Day

Stay in this community (yrs., or mos., or days): One Day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Appletown - Rural Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Boonsboro Md. R.2

(If rural give LOCATION)

2(o) IF VETERAN, NAME WAR: - None -

3. (a) FULL NAME: Merril Eugene Hines

3. (b) Social Security Number: 220-18-1021

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Hilda Hines

6 (c) If alive, give age: 29 years

7. Birth date of deceased (mo., day, yr.): March - 12 - 1914

8. AGE:

Years	Months	Days	If less than one day
31	1	13	____ hrs. ____ min.

9. Birthplace: Near Boonsboro Wash. Co. Md. (Town, county, and state)

10. Usual occupation: Machinist Helper

11. Industry or business: Baltimore & Ohio R.R.

FATHER

12. Name: Roy Hines

13. Birthplace: Near Boonsboro Wash. Co. Md.

MOTHER

14. Maiden name: Mary Shoemaker

15. Birthplace: Near Boonsboro Wash. Co. Md.

16. Informant: Mrs. Hilda Hines

Address: Boonsboro Md. R.2

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 28 1944 (month) (day) (year)

Cemetery or crematory: Boonsboro Cemetary

Location: Boonsboro Md.

18. Funeral director: Wm. J. Bast & Son

Address: Boonsboro Md.

19. April 27 1945 (Date rec'd by registrar) Ghost Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr 25 1945 at 5:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 24 1945 to Apr 25 1945, and that I last saw him alive on Apr 25 1945

Immediate cause of death	DURATION
Pulmonary embolism	few minutes
Due to: Prostatic abscesses	2 wks +
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy: Pulmonary embolism; Prostatic abscesses

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. L. Houghton M.D. (M. D. or other)

Address: Hagerstown Md. Date signed: Apr 25/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 837

04258

FILM No. G 95 JUN 13 1945

CERTIFICATE OF DEATH

Reg. Diat. No. 306

1. PLACE OF DEATH:

County: Washington

City or town: Smithsburg and

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Two years

Hospital, institution, or street address where death occurred: -

How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Smithsburg Rfd

(If outside city or town limits, write RURAL and give nearest town)

Street No. - - -

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Susan Hollingsworth

3.(b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: -

6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): 4-11-1866

8. AGE:

Years	Months	Days	If less than one day
78	5	18	- hrs. - min.

9. Birthplace: Near Leitersburg Md (Town, county, and state)

10. Usual occupation: Home Keeping

11. Industry or business:

FATHER

12. Name: David Stouffer

13. Birthplace: Near Leitersburg Md

MOTHER

14. Maiden name: Mary Elizabeth Brewer

15. Birthplace: Gettysburg Pa

16. Informant: Mrs Clyde Taylor

Address: Smithsburg Md

17. Burial, (cremation, entombment?) Date thereof: 4 (month) 24 (day) 1945 (year)

Cemetery or crematory: Smithsburg

Location: Smithsburg Md

18. Funeral director: Geo. W. Stouffer

Address: Smithsburg Md

19. April 23 1945 (Date rec'd by registrar) Geo. W. Ferguson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 22 1945, at 9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 1945 to April 22 1945

and that I last saw h... alive on April 22 1945

	DURATION
Immediate cause of death: Cerebral Thrombosis	3 days
Due to: Arterio & Cerosis (Generalized)	10 yrs
Due to: ( )	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: G. C. K. Ohler M. D. or other

Address: Smithsburg Md Date signed: 4/23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (160-a)

CERTIFICATE OF DEATH

04259

Reg. Dist. No. 303

1. PLACE OF DEATH:

County: Washington

City or town: Clearspring Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Clearspring Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Infant Son Of Mr.&Mrs Otho Horst

3.(b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24 1945

8. AGE: Years 0 | Months 0 | Days 1 | If less than one day hrs. min.

9. Birthplace Clearspring, Md. Rural
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Otho Horst

13. Birthplace Washington Co.

MOTHER 14. Maiden name Anna Hoover

15. Birthplace Washington Co.

16. Informant Mrs. Otho Horst

Address Clearspring, Md. Rural

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 25 1945 (month) (day) (year)

Cemetery or crematory Menonite Cemetery

Location Near Clearspring, Md.

18. Funeral director Snyder-Rowland

Address Clearspring, Md

April 25 1945 Joseph W. Murray
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1945 at 2:00 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 24 1945 to April 25 1945

and that I last saw him alive on April 24 1945

Immediate cause of death	DURATION
Cerebral hemorrhage of the newborn	1 day
Due to Prolonged and difficult labor of mother	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations none.

Date of op. none.

Autopsy results none.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Archie Robert Colvin M. D. or other

Address Clearspring Md Date signed 4/25/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Prather

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92d

CERTIFICATE OF DEATH

04260

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Years
Hospital, institution, or street address where death occurred:
125 East Washington St.
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 125 East Washington St
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Mrs. Myrtle Milum Hulen

3.(b) Social Security Number: None

4. Sex: Female
5. Color or race: white
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Samuel H.
6.(c) If alive, give age: 49 years
7. Birth date of deceased (mo., day, yr.): July b 13 1897

8. AGE: Years: 47 | Months: 8 | Days: 27 | If less than one day: ....hrs. ....min.

9. Birthplace: Genoa Wayne Co. W. Va.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home

FATHER
12. Name: Robert F. Milum
13. Birthplace: Genoa W. Va.

MOTHER
14. Maiden name: No Record
15. Birthplace: No Record

16. Informant: Samuel H. Milum
Address: Hagerstown Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 4/11/45 (month) (day) (year)
Cemetery or crematory: Genoa Cemetery
Location: Genoa W. Va.

18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.

19. April 11 1945 (Date rec'd by Registrar) Chas. H. Bowers, Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH: April 10 1945 19..., at 3.30 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 10 19 45, to Apr. 10 19 45
and that I last saw h[illegible] alive on April 10 19 45

Immediate cause of death — DURATION

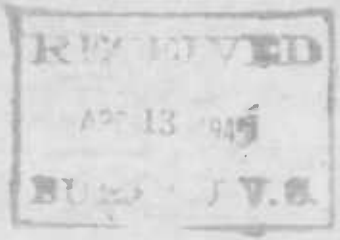
Myocardial insufficiency — 6 mo.
Due to: Chronic Myocarditis — 5 yrs.
Due to: Chronic endocarditis — 20 yrs.
Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ....Date of....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: P. H. Slatter M. D.
Address: Hagerstown Date signed 4/10/45


RECEIVED
APR 13 1945
U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

Reg. Dist. No. 0426 1352

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 weeks

Hospital, institution, or street address where death occurred: Washington County Home

How long in hospital or institution? 4 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Middleburg pike (Rural)

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Isaiah D. Hull.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Martha Hull

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): October 4, 1869.

8. AGE: Years	Months	Days	If less than one day
75	6	2	..... hrs. ..... min.

9. Birthplace: Mill Stone, Md. (Town, county, and state)

10. Usual occupation: Retired farm work.

11. Industry or business:

FATHER — 12. Name: Issac Hull.

13. Birthplace: Washington County, Md.

MOTHER — 14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Arthur Hull.

Address: Williamsport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 9, 1945 (month) (day) (year)

Cemetery or crematory: St Paul

Location: Hagerstown, route 40

18. Funeral director: Fred W. Kraiss.

Address: Hagerstown

19. April 9 1945 (Date rec'd by registrar) Chas. H. Beard Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 6 19 45 at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 45 to April 6 19 45

and that I last saw him alive on April 4 19 45

Immediate cause of death	DURATION
Coronary Occlusion.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

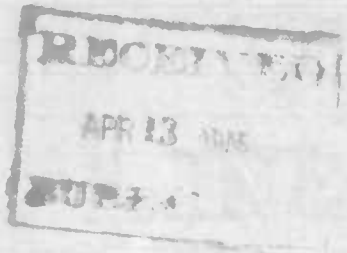
23. SIGNATURE: Ernest J Poole M.D. M. D. or other

Address: Hagerstown Md. Date signed 4/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


APR 13

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

04262

Reg. Dist. No. 305

1. PLACE OF DEATH:

County: Washington

City or town: Near Boonsboro - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: Boonsboro Md.

How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Boonsboro 'Rural'

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Boonsboro Md.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Nancy Catherine Hutzell

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June - 14 - 1942

8. AGE:

Years	Months	Days	If less than one day
2	10	14	..... hrs. ..... min.

9. Birthplace: Boonsboro Wash. Co. Md.

(Town, county, and state)

10. Usual occupation: None

11. Industry or business: at Home

FATHER

12. Name: Charles Hutzell

13. Birthplace: Rohrersville Wash. Co. Md.

MOTHER

14. Maiden name: Evelyn Stine

15. Birthplace: Locust Grove Wash. Co. Md

16. Informant: Mr. Charles H. Hutzell

Address: Boonsboro Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May-1-1945 (month) (day) (year)

Cemetery or crematory: Locust Grove Cemetery

Location: Locust Grove Md.

18. Funeral director: (W.H.) Bart & Sons

Address: Boonsboro Md.

19. April 30. 1945 John H. Bart

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 28 1945 at 8 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 26 1945 to April 28 1945

and that I last saw h alive on April 28 1945

Immediate cause of death: (a) Asphyxia (Smoke)

DURATION
10 Min

Due to: .....

Due to: .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 4/28/45

Where did injury occur? Boonsboro (City or town) Md. (County) Home (State)

Injured at home, farm, Industry, public place (where?) Home

Means of injury: Asphyxia from Smoke & Fire Injured at work?

23. SIGNATURE: J. H. Beachley M.D.

M. D. or other

Address: Hagerstown, Md. Date signed: 4/28/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of age is shown on FILM No. G 95

STATE OF MARYLAND—CERTIFICATE OF DEATH

JUN 13 1945

04263

1. PLACE OF DEATH (131-a)

County Washington Registration Dist. No. 300

Village or City Sharpsburg, Md. No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Annie Gertrude Ingram If U. S. Veteran, specify WAR

(a) Residence: No. Sharpsburg, Md. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	White	Widow

5a. If married, widowed, or divorced — HUSBAND of (or) WIFE of: Charles W. Ingram

6. DATE OF BIRTH (month, day, and year) Oct 25 1870

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74 75	5	8	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: House work

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: Home

10. Date deceased last worked at this occupation (month and year): 2 yrs

11. Total time (years) spent in this occupation: 60yrs

12. BIRTHPLACE (city or town) (State or country): Bakerton, W.Va.

FATHER

13. NAME: Thomas Welsh

14. BIRTHPLACE (city or town) (State or country): Harpers Ferry, W.Va

MOTHER

15. MAIDEN NAME: Unknown

16. BIRTHPLACE (city or town) (State or country): Unknown

17. INFORMANT: Mrs Chester A. Bettinger

(Address) Hagerstown, Md.

18. BURIAL, CREMATION, OR REMOVAL

Place Samples Manor, Md. April 5, 1945

19. UNDERTAKER: J. Lu Eackles.

(Address) Bolivar, W.Va.

20. FILED 4-3, 1945 Chas O Boyer

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH April (Month) 2 (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1943 to Apr. 2, 1945; that I last saw h[illegible] alive on Apr. 1, 1945; death is said to have occurred on the date stated above, at 10:30 P. M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
General Arteriosclerosis	1
Other Contributory Causes of importance:	
Prov. Intestinal Infection	1

Name of operation: Date of:

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, In HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Walter H. Schuler M. D.

(Address) Sharpsburg, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. Care should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a **clerk.**

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85a)

CERTIFICATE OF DEATH

04264

Reg. Diat. No. 305

1. PLACE OF DEATH:
County Washington
City or town Boonsboro
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years
Hospital, institution, or street address where death occurred:
N. Main St.
How long in hospital or institution? at Home.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Boonsboro
(If outside city or town limits, write RURAL and give nearest town)
Street No. N. Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME Leah Virginia James

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife John H. James.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 21. 1870

8. AGE: Years 74 | Months 7 | Days 11 | If less than one day ..... hrs. ..... min.

9. Birthplace Shepherdstown W. Va.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER
12. Name J. C. Shaw
13. Birthplace Shepherdstown W. Va.

MOTHER
14. Maiden name Frances M. Crow
15. Birthplace Seneca Md.

16. Informant John W. James
Address Boonsboro Md

17. Interment (Burial, cremation, or removal. Which?) Date thereof April 5. 1945 (month) (day) (year)
Cemetery or crematory Boonsboro Mausoleum
Location Boonsboro Md.

18. Funeral director Wm. J. Bart & Sons
Address Boonsboro Md.

19. April 5. 1945 John H. Bart
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2" 1945 at 10.15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 11" 1945, to April 2" 1945
and that I last saw h.. alive on April 2" 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 days
Due to Arterial Hypertension	6 years.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE J. Hubert Nader M.D.
M. D. or other
Address Boonsboro, Md. Date signed 4/4/45.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1752)

CERTIFICATE OF DEATH

Dr. Beachley

04265

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Chewsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Years
Hospital, Institution, or street address where death occurred: Near Chewsville Md.
How long in hospital or institution? –

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 833 Maryland Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME: Charles William Jenkins

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Elizabeth
6.(c) If alive, give age: – years

7. Birth date of deceased (mo., day, yr.): May 8 1873

8. AGE: Years	Months	Days	If less than one day
71	10	21	..... hrs. ..... min.

9. Birthplace: Rileyville Page Co. Va.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: –

FATHER
12. Name: Frank Jenkins
13. Birthplace: Stanley Va.

MOTHER
14. Maiden name: Anna Daddisman
15. Birthplace: Stanley Va.

16. Informant: Carson Jenkins
Address: Baltimore Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 1, 1945 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown Md.

18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.

19. May 1 19 45 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 29, 19 45, at 12:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 29 19 45 to April 29 19 45 and that I last saw h.. alive on April 29 19 45

Immediate cause of death	DURATION
Coiled Aneurism	1 min
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 4/29/45
Accident, suicide, or homicide: Accident Date of
Where did injury occur? RFD #1 (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Farm
Means of injury: Granule Injured at work? Yes

23. SIGNATURE: J. S. Beachley M. D. or other
Address: Hagerstown Date signed: 4/29/45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47-A

T
04266

CERTIFICATE OF DEATH

Reg. Dist. No. 306

1. PLACE OF DEATH:
County: Washington
City or town: Pondsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mos.
Hospital, Institution, or street address where death occurred: -
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Pondsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. - - - -
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: Edward. Kelbaugh.

3.(b) Social Security Number: none.

4. Sex: Male
5. Color or race: white
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Katie. Kelbaugh. jr
6.(c) If alive, give age: 67 years
7. Birth date of deceased (mo., day, yr.): 9-1879

8. AGE: Years: 65 Months: 7 Days: 1 If less than one day: - hrs. - min.

9. Birthplace: Foxville Fred Co md
(Town, county, and state)
10. Usual occupation: Laborer.
11. Industry or business: - - -

FATHER
12. Name: Edward. Kelbaugh.
13. Birthplace: Near Foxville. Fred Co.

MOTHER
14. Maiden name: Matilda. Allbery
15. Birthplace: Fred. Co. md

16. Informant: Katie. Kelbaugh.
Address: Smithsburg md

17. Burial. Date thereof: 4-29-1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Smoketown.
Location: Smoketown. Was. Co. md

18. Funeral director: Geo. B. Hoover
Address: Smithsburg md

19. April 28 1945 (Date rec'd by registrar) Geo. W. Ferguson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 27, 1945 at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 13 1944, to Oct. 7 1944
and that I last saw him alive on Oct. 7, 1944

Immediate cause of death:

Due to: Carcinoma Larynx

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: Bx of larynx, ... Baltimore ... Date of op. Oct. 7 1944

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: Hagerstown. Md Date signed: April 28 1945

Pr. Grads.

(M)

(T)

(T)

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

04267

Reg. Diat. No. 305

1. PLACE OF DEATH:

County Washington

City or town Boonsboro

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years.

Hospital, Institution, or street address where death occurred:

St. Paul St.

How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Boonsboro

(If outside city or town limits, write RURAL and give nearest town)

Street No. St. Paul St.

(If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME Anna Elizabeth Maddrau

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

B.(b) Name of husband or wife James E. Maddrau

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March. 28. 1873

8. AGE: Years	Months	Days	If less than one day
72	0	20	..... hrs. ..... min.

9. Birthplace St. James Wash. Co. Md.
(Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business Own Home

FATHER 12. Name Lawson Wilkerson

FATHER 13. Birthplace Wolfsville Frd. Co. Md.

MOTHER 14. Maiden name Julia Fogle

MOTHER 15. Birthplace Woodstock Virginia

16. Informant Mrs. Glenn De Walt

Address 858 Virginia Ave Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April. 21. 1945 (month) (day) (year)

Cemetery or crematory Boonsboro Cemetary

Location Boonsboro Md.

18. Funeral director Wm. D. Bast & Sons

Address Boonsboro Md.

19. April. 20. 1945 (Date rec'd by registrar) John H. Bast Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18" 1945 at 7.30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 16" 1945 to April 18" 1945

and that I last saw h... alive on April 18" 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 Days.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. Hubert Nader. M.D. M. D. or other

Address Boonsboro, Md. Date signed 4/19/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 927

CERTIFICATE OF DEATH

11426 Hc. 618 Hc.

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs
Hospital, institution, or street address where death occurred: 122 West Bethel St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 122 West Bethel St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Daniel Matthew Miller

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Widowed

6.(b) Name of husband or wife Florence Miller
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 27 1874

8. AGE: Years 71 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Hagerstown Md (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name George C. Miller
13. Birthplace Williamsport Md

MOTHER
14. Maiden name Mollie Hill
15. Birthplace Hagerstown Md

16. Informant Mildred Miller
Address 122 West Bethel St

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 14 45 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery
Location Hagerstown Md

18. Funeral director William H. Downey
Address 291 Frederick St

19. April 14 1945 (Date rec'd by registrar) Chas H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-10-1945 at 3P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to 4/10 1945 and that I last saw him alive on 4/1 - 1945

Immediate cause of death	DURATION
Chronic Endocarditis	21
Arteria-sclerosis	2
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ✓ Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Victor D. Miller
DR. VICTOR D. MILLER. M. D. or other
Address 131 W. WASHINGTON ST. Date signed 4/11 1945
HAGERSTOWN, MD.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

64269

Reg. Dist. No. 303

1. PLACE OF DEATH:
County: Washington
City or town: Big Pool, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Ten Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Big Pool Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Grant Mills

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mollie Mills
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 4 1868

8. AGE: Years	Months	Days	If less than one day
77	2	0	..... hrs. ..... min.

9. Birthplace: Washington County (Town, county, and state)
10. Usual occupation: Retired Laborer
11. Industry or business

FATHER
12. Name: Jacob Mills
13. Birthplace: Washington County

MOTHER
14. Maiden name: Mary Ainsell
15. Birthplace: Washington County

16. Informant: Mrs. Blanche Eichelberger
Address: Big Pool, Rural

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 6 1945 (month) (day) (year)
Cemetery or crematory: Church Of God
Location: Blairs Valley

18. Funeral director: Snyder-Rowland
Address: Clearspring, Md.

Filed April 6 1945 (Date rec'd by registrar) Joseph W. Murray Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 4 1945, at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 5 1945 to April 4 1945 and that I last saw him alive on March 28 1945

Immediate cause of death	DURATION
Hypertensive cardio-vascular renal disease	?
Due to: Senility	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None.
Date of op.
Autopsy results: None.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Arlie Robert Coker M. D. or other
Address: Clearspring Md. Date signed 4/6/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. B. B. Knlesley

04270

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 Mos.

Hospital, institution, or street address where death occurred: Washington Co. Hospital

How long in hospital or institution? 9 Mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Dagmar Hotel

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Miss Louise Moller

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 18,1857

8. AGE: Years	Months	Days	If less than one day
88	1	2	..... hrs. ..... min.

9. Birthplace: Ronne, Bornholm Denmark (Town, county, and state)

10. Usual occupation: Hotel Manager

11. Industry or business: Retired

FATHER — 12. Name: Niels Moller

FATHER — 13. Birthplace: Ronne, Bornholm, Denmark.

MOTHER — 14. Maiden name: Anna Katherine Moller

MOTHER — 15. Birthplace: Ronne, Bornholm Denmark.

16. Informant: Mrs M.P. Moller Sr.

Address: Hagerstown Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 23/45 (month) (day) (year)

Cemetery or crematory: Mausoleum Rose Hill Cem.

Location: Hagerstown, Maryland

18. Funeral director: Andrew K Coffman

Address: Hagerstown, Maryland.

19. April 23 1945 (Date rec'd by registrar) Chas. H. Boverd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20, 1945 at 6 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 20, 1944 19..., to April 20, 1945 and that I last saw her alive on April 20, 1945 19...

	DURATION
Immediate cause of death: Hypostatic pneumonia	3 days
Due to:	
Due to:	
Other conditions: General arteriosclerosis	Indef.
Fractured right hip	9 mos.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 7/20/44

Where did injury occur? Apartment, Dagmar Hotel, Hag. Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Own apartment

Means of injury: fall Injured at work?

23. SIGNATURE: B B Knisley M.D. M. D. or other

Address: 148 W. Washington St. Date signed: 4/21/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of age is shown on FILM No. G 95 JUN 13 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-C)

CERTIFICATE OF DEATH

04271

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 years

Hospital, Institution, or street address where death occurred: 810 Washington Square

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 810 Washington Square
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Joseph L. Moore

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Iva V. Moore

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): April 4, 1870

8. AGE: Years	Months	Days	If less than one day
74 ~~75~~	0	0	...hrs. ...min.

9. Birthplace: Green Spring Furnace, Md.
(Town, county, and state)

10. Usual occupation: Retired R.R. Engineer

11. Industry or business

FATHER 12. Name: Mentor Moore

13. Birthplace: Clearspring, Maryland

MOTHER 14. Maiden name: Rebecca Robinson

15. Birthplace: Clearspring, Maryland

16. Informant: Mrs. Joseph L. Moore

Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-6-45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Maryland

18. Funeral director: C. M. Suter & Sons

Address: Hagerstown, Maryland

19. April 6 19 45 Chas. H. Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/3 19 45 at ~~a~~ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 45 to 4/3 19 45

and that I last saw h~~e~~ alive on 4/3 19 45

Immediate cause of death: Carcinoma of Stomach — DURATION: ?

Due to: ~

Due to: ~

Other conditions: ~

(Include pregnancy within 3 months of death)

Major findings of operations: ~ Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Victor D. Miller
DR. VICTOR D. MILLER. M. D. or other

Address 131 W. WASHINGTON, ST. HAGERSTOWN, MD. Date signed 4/4 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-0

CERTIFICATE OF DEATH

Reg. Dist. No. 316

1. PLACE OF DEATH:
County Washington
City or town Near Keedysville Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years.
Hospital, Institution, or street address where death occurred:
Keedysville Md. R. 1.
How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Near Keedysville Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Keedysville Md. R. 1.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME Rosa Belle Nicodemus
3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Jacob E. Nicodemus
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July - 21 - 1877

8. AGE: Years	Months	Days	If less than one day
67	8	25	..... hrs. ..... min.

9. Birthplace Near Brathedsville Wash. Co. Md.
(Town, county, and state)
10. Usual occupation Housekeeper
11. Indusfry or business Own Home.
FATHER 12. Name John Springer
13. Birthplace Wash. Co. Md.
MOTHER 14. Maiden name Mary Kohlenburg
15. Birthplace Fred. Co. Md.
16. Informant Mrs. David Easterday
Address Keedysville Md. R. 1
17. Burial - (Burial, cremation, or removal. Which?) Date thereof April - 19 - 1945 (month) (day) (year)
Cemetery or crematory Boonsboro Cemetery
Location Boonsboro Md.
18. Funeral director Wm. D. Bast and Sons
Address Boonsboro Md.
19. April 18 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1945 at 4 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2 1945 to April 16 1945 and that I last saw her alive on April 16 1945

Immediate cause of death	DURATION
Chronic Myocarditis	5 yr.
Due to Senile Dementia	7 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of Injury ..... Injured at work?

23. SIGNATURE G. W. LeVan M. D.
M. D. or other
Address Boonsboro, Md. Date signed 4/17/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-3)

CERTIFICATE OF DEATH

04273

Reg. Dist. No. 304

1. PLACE OF DEATH:
County: Washington
City or town: Hancock Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hancock Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Annie N. Norris

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 27 1867

8. AGE: Years: 77 | Months: 10 | Days: 28 | If less than one day: hrs. min.

9. Birthplace: Washington County (Town, county, and state)

10. Usual occupation: Home Work

11. Industry or business

FATHER
12. Name: Charles Norris
13. Birthplace: Washington Co.

MOTHER
14. Maiden name: Maria Rockwell
15. Birthplace: Washington Co.

16. Informant: George T. Norris
Address: Hancock, Rural

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 27 1945 (month) (day) (year)
Cemetery or crematory: Norris Cemetery
Location: Near Hancock, In Alleganey C.;

18. Funeral director: Snyder-Rowland
Address: Hancock, Md.

19. April 26 19 45 (Date rec'd by registrar) Lillian E. Jenkins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 25 19 45, at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1904 19 to 1945 - 4/25
and that I last saw her alive on 4/13/45 - 19

Immediate cause of death	DURATION
Mitral Stenosis	
Due to	
Due to	
Diher conditions	

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H. E. Fable M.D. M. D. or other
Address: Hancock, Md. Date signed 4/26/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of year of birth is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

04274

CERTIFICATE OF DEATH

FILM No. G 95 JUN 13 1945

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs
Hospital, Institution, or street address where death occurred: 210 E. Jonathan St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 210 E. Jonathan St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Montague M. F. Robinson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 12 1850

8. AGE: Years	Months	Days	If less than one day
94			..... hrs. ..... min.

9. Birthplace: Beaver Dam Pa.
(Town, county, and state)

10. Usual occupation: Minister

11. Industry or business

FATHER 12. Name: Silvia Robinson

13. Birthplace: Unknown

MOTHER 14. Maiden name: Elina Robinson

15. Birthplace: Unknown

16. Informant: Sara Brooks

Address: 212 N. Jonathan

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Apr 8. 45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown Md.

18. Funeral director: William H. Bowman

Address: 291 Freelinces St

19. Apr. 8. 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 5 1945, at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1943, to Apr. 5 1945 and that I last saw h[illegible] alive on Apr. 1 5 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 days
Due to Hypertension	3 "
Due to Arterio Sclerosis	3 "
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: B. F. Rathers M. D.

Address: Hagerstown, Md. Date signed 4/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04275

Reg. Dist. No. 3021

1. PLACE OF DEATH:
County Washington
City or town Hagerstown R.F.D.#1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1month
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown R F D #1
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lottie M Sampsell

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife John A Sampsell
6.(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Jan. 16 1893

8. AGE: Years	Months	Days	If less than one day
52	3	9	hrs. min.

9. Birthplace Downsville Md (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business home

FATHER
12. Name Robert Lee Bowers
13. Birthplace Downsville Md

MOTHER
14. Maiden name Mary Jane Fowler
15. Birthplace Downsville Md.

16. Informant John A. Sampsell
Address Hagerstown R.F.D. #1

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 29 1945 (month) (day) (year)
Cemetery or crematory Greenlawn Cem
Location Williamsport Md

18. Funeral director Edith V. Leaf
Address Williamsport Md

19. April 27 1945 (Date rec'd by registrar) Clark Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1945 at 1:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1944 to Apr. 23 1945
and that I last saw h[illegible] alive on Apr. 23 1945

	DURATION
Immediate cause of death Myocardial insufficiency	
Due to Chronic myocarditis	1 yr.
Due to Pulmonary tuberculosis	3 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE B Luther M. D. or other
Address Hagerstown Date signed 4/27/45

VS A15 (T)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

T 114276

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, Institution, or street address where death occurred:
224 N. Potomac St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 224 N. Potomac. St.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME Joseph L. Shank

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Laura V. Shank
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 5 1865

8. AGE: Years	Months	Days	If less than one day
79	5	25	..... hrs. ..... min.

9. Birthplace Woodsboro Fred. Md.
(Town, county, and state)
10. Usual occupation None
11. Industry or business None
FATHER 12. Name George W. Shank
13. Birthplace Woodsboro Md.
MOTHER 14. Maiden name Belinda E. Baker
15. Birthplace Woodsboro Md.
16. Informant Mrs. Mary B. Saxten
Address Hagerstown Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 2. 1945 (month) (day) (year)
Cemetery or crematory Mt. Hope
Location Woodsboro Md.
18. Funeral director Scott F. Minnich & Son
Address Hagerstown Md.
19. May 1 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1945 at 7:45a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-19- 1944 to April 30 1945
and that I last saw h... alive on April 29, 1945

	DURATION
Immediate cause of death Coronary Occlusion	4-28-45
Due to Left Hemiplegia & Cerebral Hemorrhage	4-26-45
Due to Arteriosclerosis Mitral Insufficiency	4 yrs. 4 yrs.
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations None Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. Horace Yeager, M. D. or other
Address Hagerstown. Md. Date signed Apr. 30, 45.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of age of deceased is shown on FILM No. G95 JUN 16 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04277

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, Institution, or street address where death occurred:
831 West Washington
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 831 West Washington
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME Mary Elizbeth Shimer

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

B.(b) Name of husband or wife George M. Shimer
6.(c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) April 29, 1866

8. AGE: Years	Months	Days	If less than one day
~~79~~ 78	0	25	hrs. min.

9. Birthplace McConnellsburg Fulton Pa.
(Town, county, and state)
10. Usual occupation House Wife
11. Industry or business Own Home

FATHER
12. Name George Snyder
13. Birthplace Near Mc.Connellsburg Pa,

MOTHER
14. Maiden name Mary Pittman
15. Birthplace Near McConnellsburg Pa.

16. Informant George M. Shimer
Address Hagerstown Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof April 25.1945 (month) (day) (year)
Cemetery or crematory Union Cemetery
Location McConnellsburg Pa.

18. Funeral director B.M.Gress
Address McConnellsburg Pa.

19. April 25 1945 (Date rec'd by registrar) C Frost Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1945, at 10:30a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 3/26/45 19.., to 4/24/45 19..
and that I last saw h.. alive on 4/23/45 19..

Immediate cause of death	DURATION
Congestive Heart Failure	2 years
Due to	
Due to Hypertensive heart disease	10 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Hagerstown Md
Address Hagerstown Md. M. D. or other
Date signed 4/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Miller

04278

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (25)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Days

Hospital, Institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 4 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maruland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1043 Spruce St.

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME Mrs. Annie Gertrude Shingleton

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Charles R.

6.(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) November 4 1880

8. AGE: Years	Months	Days	If less than one day
64	5	5	....hrs. ....min.

9. Birthplace Romney Hampshire Co. W. Va.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER

12. Name Isaac Clark

13. Birthplace Winchester Va.

MOTHER

14. Maiden name Jennie Wolford

15. Birthplace Romney W. Va.

16. Informant Charles R. Shingleton

Address Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/8/45 (month) (day) (year)

Cemetery or crematory Rest Haven cemetery

Location Hagerstown Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. April 7 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH April 6 1945 at 4.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/31- 1945 to 4/6- 1945 and that I last saw h.. alive on 4/6-1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	4 days
Due to: Broncho-Pneumonia	2 days.
Due to: —	
Other conditions — —	

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results O

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE V. D. Miller DR. VICTOR D. MILLER M. D. or other

Address 131 W. WASHINGTON, ST. HAGERSTOWN, MD. Date signed 4/6-1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 924

CERTIFICATE OF DEATH

04279

Reg. Dist. No. 303

1. PLACE OF DEATH:

County Washington Co

City or town Big Spring R.F.D. #1 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Washington

City or town Big Spring R.F.D. #1 (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Charles Emory Show

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Amatha Porell

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14 1864

8. AGE: Years	Months	Days	If less than one day
80	10	1	hrs. min.

9. Birthplace Sharpsburg R.F.D. #1 (Town, County, and State)

10. Usual occupation Laborer

11. Industry or business Farm work

FATHER 12. Name Rith Show

13. Birthplace Sharpsburg R.F.D. #1

MOTHER 14. Maiden name Jennie Taylor

15. Birthplace Sharpsburg R.F.D.#1

16. Informant Eva Shaw

Address Big Spring R.F.D.#1

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 18 1945 (month) (day) (year)

Cemetery or crematory Rose Hill C

Location Clearspring Md

18. Funeral director Edith V. Leaf

Address Williamsport Md

April 18 1945 (Date rec'd by registrar) J Raphael Murray Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16, 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1942 to April 16 1945 and that I last saw him alive on April 15 1945

Immediate cause of death	DURATION
Chronic Endocarditis	3 yrs.
Due to Arteriosclerosis and Myocardial Sclerosis	6 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE David R. Brewer M.D M. D. or other

Address Clear Spring Md Date signed 4/18/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

Dr. Beachley 04280

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? –

Hospital, institution, or street address where death occurred:

Washington county Hospital

How long in hospital or institution? –

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 334 Central Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: John Valentine Showe

3.(b) Social Security Number: 214-09-0627

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age: – years

7. Birth date of deceased (mo., day, yr.): August 29 1904

8. AGE: Years	Months	Days	If less than one day
40	8	0	...hrs. ...min.

9. Birthplace: Fairplay Wash. co. Md (Town, county, and state)

10. Usual occupation: Letterkenny Ordnance Depot

11. Industry or business: Clerk

FATHER

12. Name: Frisby T. Showe

13. Birthplace: Fairplay Md.

MOTHER

14. Maiden name: Anna Jacobs

15. Birthplace: Fairplay Md.

16. Informant: Ivan L. Showe

Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/1/45 (month) (day) (year)

Cemetery or crematory: Manor Cemetery

Location: near Tilghmanton Md.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19. April 30 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 29 1945 19... at ...M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 29 19 45 to April 29 19 45 and that I last saw h... alive on April 29 19 45

Immediate cause of death: Coronary Sclerosis — DURATION

Due to: — DURATION

Due to: — DURATION

Other conditions — DURATION

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.

Autopsy results: Coronary Sclerosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. D. Beachley M. D.

Address: Hagerstown Md. Date signed: 4-30-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Kneisley

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

CERTIFICATE OF DEATH

04281

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 Years
Hospital, institution, or street address where death occurred:
140 East Washington St.
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 140 East washington St
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Mrs. Anna Marie Spielman

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: James H.
6.(c) If alive, give age: —
7. Birth date of deceased (mo., day, yr.): January 23 1859

8. AGE: Years	Months	Days	If less than one day
86	2	12	hrs. min.

9. Birthplace: Hagerstown Wash. Co. Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home
FATHER 12. Name: Hiram Lushbaugh
13. Birthplace: Hagerstown Md.
MOTHER 14. Maiden name: Mary A. Ridenour
15. Birthplace: Hagerstown Md.
16. Informant: Miss A. Louise Spielman
Address: Hagerstown Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/7/45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown Md.
18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.
19. April 7 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH: April 5 1945 19 at 8.20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ... and that I last saw h... alive on ... 19 ...

Immediate cause of death	DURATION
Vascular Hypertension	5yrs
Due to: Cerebral hemorrhage	2yrs
Due to: Chr. myocarditis	1 yr.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: D. Robert Wells DEPUTY MEDICAL EXAM. WASH. CO., MD.
M. D. or ...
Address: Hagerstown, Md. Date signed: Apr. 6/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

Dr. Kritzer 4282

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 Hours
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 4 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 6 Marbern Road
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Margaret June Stewart

3.(b) Social Security Number: 212-24-6022

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: --
8.(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): March 21 1928

8. AGE: Years	Months	Days	If less than one day
17	1	0	... hrs. ... min.

9. Birthplace: Oakland Garrett Co. Md.
(Town, county, and state)
10. Usual occupation: In School
11. Industry or business: --

FATHER
12. Name: Robert L. Stewart
13. Birthplace: Frostsburg Md.

MOTHER
14. Maiden name: Ella May Bothwell
15. Birthplace: Westernport Md.

18. Informant: Robert L. Stewart
Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/24/45 (month) (day) (year)
Cemetery or crematory: Alleganey Cemetery
Location: Frostsburg Md.

18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.

19. April 23 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 21 1945 at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 16- 1945, to April 21- 1945
and that I last saw h.e alive on April 21- 1945

Immediate cause of death	DURATION
Diabetic Coma -	10 hrs -
Due to Diabetes Mellitus -	
Due to	
Other conditions Chicken-pox -	5 Days -

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Dr. Kritzer M. D. or other
Address: Hagerstown Md. Date signed 4/25/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Diat. No. 04283 304

1. PLACE OF DEATH:

County: Washington

City or town: Rural Hancock

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Washington

City or town: Rural Hancock

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Locher Farm

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Infant

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 20, 1945

8. AGE: Years | Months | Days | If less than one day: hrs. 30 min.

9. Birthplace: Hancock Wash Co., Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER

12. Name: Emmet Stewart Stotler

13. Birthplace: Morgan Co. W. Va.

MOTHER

14. Maiden name: Mary Madeline Shepherd

15. Birthplace: Morgan Co. W. Va.

16. Informant: Emmet Stotler

Address: Hancock Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 20-45 (month) (day) (year)

Cemetery or crematory: Clifpine

Location: Morgan Co. W. Va.

18. Funeral director: Emmet Stotler

Address: Hancock Md.

19. Apr. 20 1945 (Date rec'd by registrar) Lillian E Jenkins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20 1945 at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-20 1945 to 4-20 1945 and that I last saw h... alive on 4-20 1945

Immediate cause of death	DURATION
Atelectasis	
Short but difficult delivery	
Due to: Nephritis (mother) (b)	1 mo.
Due to:	
Other conditions: Treated toxemia of pregnancy	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Herbert R. Tobias M.D. M. D. or other

Address: Hancock Md. Date signed: 4-20-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr. Beachley

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 74-a

CERTIFICATE OF DEATH

104284

Reg. Dist. No. 302

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 Years
Hospital, institution, or street address where death occurred:
122 Clarkson Ave
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 122 Clarkson Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Mrs. Clara Amanda Stover

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife: Edward
6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): November 14 1900

8. AGE: Years	Months	Days	If less than one day
44	5	5	....hrs. ....min.

9. Birthplace: Waynesboro Franklin co. Pa.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home
FATHER 12. Name: George Rowe
13. Birthplace: Waynesboro pa.
MOTHER 14. Maiden name: Anna Heckman
15. Birthplace: Frederick Md.
16. Informant: Merle Stull
Address: Hagerstown Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/22/45 (month) (day) (year)
Cemetery or crematory: Prices Cemetery
Location: near Waynesboro pa/
18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.
19. Apr. 24 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19 1945 19 at 7 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 18 19 45 to April 19 19 45
and that I last saw h[illegible] alive on April 19 19 45
Immediate cause of death: Coronary Thrombosis — DURATION: 5

	DURATION
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. H. Beachley M. D.
Address: Hagerstown Md. Date signed: 4/20/45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04285

CERTIFICATE OF DEATH

Reg. Dist. No. 306

1. PLACE OF DEATH:
County Washington
City or town Smithsburg md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 mo.
Hospital, institution, or street address where death occurred: –
How long in hospital or institution? –

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Wash
City or town Smithsburg md
(If outside city or town limits, write RURAL and give nearest town)
Street No. – –
(If rural, give LOCATION)
2.(a) If veteran, name war none

3.(a) FULL NAME Jula. Bell. Usey.

3.(b) Social Security Number none

4. Sex Female
5. Color or race White
6.(a) Single, married, widowed, or divorced widowed
6.(b) Name of husband or wife none
6.(c) If alive, give age – years
7. Birth date of deceased (mo., day, yr.) 7-25-1865

8. AGE: Years 79 Months 8 Days 7 If less than one day ... hrs. ... min.

9. Birthplace Philadelphia Pa.
(Town, county, and state)
10. Usual occupation Art. Teacher
11. Industry or business –

FATHER
12. Name Rev. L. J. Bell
13. Birthplace Leitersburg md

MOTHER
14. Maiden name Charlotte A. Marbourg
15. Birthplace Johns Town. Pa

16. Informant Mrs Emma Hamner
Address Smithsburg md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-4 1945 (month) (day) (year)
Cemetery or cremation Union Cemetery.
Location Greencastle Pa
18. Funeral director Geo. B. Hoover
Address Smithsburg md

19. April 3 1945 (Date rec'd by registrar) Geo. W. Ferguson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 2 1945 at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 30 1945 to Apr. 2 1945
and that I last saw her alive on Apr. 1 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	3 day
Due to Cerebral	
Due to arterio sclerosis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ...
Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work? ...

23. SIGNATURE Walter H. Bishard M. D. or other
Address 152 W main St. Waynesboro Pa Date signed Apr. 3. 45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77

CERTIFICATE OF DEATH

04286

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

240 Belview Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 240 Belview Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: George G. Viering, Jr.

3.(b) Social Security Number: 198-05-8192

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ann Viering

6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): August 3, 1905

8. AGE: Years	Months	Days	If less than one day
39	8	27	...hrs. ...min.

9. Birthplace: Johnstown, Pa. (Town, county, and state)

10. Usual occupation: Railroad Brakeman

11. Industry or business: W.M.R.R. Company

FATHER

12. Name: George G. Viering, Sr.

13. Birthplace: Johnstown, Pa.

MOTHER

14. Maiden name: Ann Lohr

15. Birthplace: Johnstown, Pa.

16. Informant: Mrs. George. G Viering, Jr.

Address: Hagerstown, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof 5-1-45 (month) (day) (year)

Cemetery or crematory: Grand View Cemetery

Location: Johnstown, Pa.

18. Funeral director: C. M. Suter & Sons

Address: Hagerstown, Maryland

19. May 1 (Date rec'd by registrar) 1945 Chas H Byers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 30 19 45 at 8P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19... to ...19...

and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
acute alcoholic narcosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: no

Date of op.

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: E. Robert Wells DEPUTY MEDICAL EXAM. WASH. CO., MD.

M. D. or

Address: Hagerstown, Md. Date signed: 5/1/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-D)

CERTIFICATE OF DEATH

Dr Hornbaker T

04287-302

Reg. Diat. No.

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Washington Co. Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Penna. County: Franklin

City or town: near Greencastle

(If outside city or town limits, write RURAL and give nearest town)

Street No. Greencastle R D #2

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: ALBERT MILLER WALLECH

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Elizabeth Wallech

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Sept 24 1875

8. AGE: Years: 69 Months: 7 Days: 5 If less than one day: hrs. min.

9. Birthplace: Greencastle Pa (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Rail Road

FATHER

12. Name: Levi Wallech

13. Birthplace: Franklin Co Pa

MOTHER

14. Maiden name: Anna Mary Shatzer

15. Birthplace: Franklin Co Pa

16. Informant: Mrs Elizabeth Wallech

Address: Greencastle R D 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 2 1945 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Near Greencastle Pa

18. Funeral director: H. E. Minnich

Address: Greencastle Pa

19. May 1 1945 (Date rec'd by registrar) Chas H Stevers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 29 1945, at 3:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/20 1945, to 4/29 1945

and that I last saw him alive on 4/29 1945

	DURATION
Immediate cause of death: Uremia	2 wks. (approx)
Due to: acute glomerulo-nephritis	4 wks.
Due to:	
Other conditions: Generalized arteriosclerosis; Arteriosclerotic Heart Disease	Unknown; "

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John N Hornbaker M. D. or other

Address: 154 W. Washington St. Hagerstown, Md. Date signed 5/1/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr Coll 4288 D-

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown N - 629 S. Potomac St
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 days
Hospital, institution, or street address where death occurred: 629 S. Potomac St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Frederick
City or town: Rural - Myersville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Church Hill
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Clara V. Warrenfeltz

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~: Soule J Warrenfeltz
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 20, 1859

8. AGE: Years	Months	Days	If less than one day
85	5	20	hrs. min.

9. Birthplace: Myersville, Frederick Co, Md (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: own Home

FATHER
12. Name: Wesley Palmer
13. Birthplace: Maryland

MOTHER
14. Maiden name: Rebecca Weddle
15. Birthplace: Maryland

16. Informant: Mrs R. C. Urich
Address: 629 S. Potomac St. Hagerstown

17. (Burial, cremation, or removal. Which?) Burial — Date thereof (month) (day) (year) April 12, 1945
Cemetery or ~~crematory~~: St John's Lutheran
Location: Church Hill, Myersville, Md

18. Funeral director: J. Thos. Bittle & Son
Address: Myersville, Md

19. April 11 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 10 1945, at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 3 1945, to April 10 1945 and that I last saw him alive on April 5 1945

Immediate cause of death	DURATION
Chr. Myocarditis	5 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert P. Conrad, M.D. M. D. or other
Address: Hagerstown, Md Date signed: 4-11-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04289

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Maugansville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred:
Maugansville Nurseing Home
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Maugansville
(If outside city or town limits, write RURAL and give nearest town)
Street No. ---
(If rural, give LOCATION)
2.(a) If veteran, name war ---

3.(a) FULL NAME: Llyod J. Weber

3.(b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: ---

6.(c) If alive, give age ---years

7. Birth date of deceased (mo., day, yr.): April 8. 1945

8. AGE:

Years	Months	Days	If less than one day
--	--	2	...hrs. ...min.

9. Birthplace: Maugansville Wash. Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER
12. Name: Leonard Weber
13. Birthplace: Maugansville Md.

MOTHER
14. Maiden name: Irene Martin
15. Birthplace: Near Mauga nsville Md.

16. Informant: Mr. Leonard Weber
Address: Near Sharpsburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 11. 1945 (month) (day) (year)
Cemetery or crematory: Rieff's Mennonite Cemetery
Location: Cearfoss Md.

18. Funeral director: Scott F. Minnich & Son
Address: Hagerstown Md.

19. April 11 1945 (Date rec'd by registrar) Chas. F. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 10 1945, at 8:50p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 8, 1945, to April 10, 1945 and that I last saw him alive on April 10, 1945

	DURATION
Immediate cause of death: Veterus of new born. (Undetermined origin)	2 days.
Due to:	
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: No operations Date of op.

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: R. A. Beel M. D. or other
Address: Hagerstown Md. Date signed 4/11/45

Corrected Copy

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 53 years
Hospital, Institution, or street address where death occurred:
329 North Potomac Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 329 North Potomac Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Walter D. Willson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Frances R. Willson
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 31, 1863

8. AGE: Years	Months	Days	If less than one day
81	7	25	..... hrs. ..... min.

9. Birthplace: Emmittsburg, Fred. Co. Md.
(Town, county, and state)
10. Usual occupation: Retired Liquor Dealer
11. Industry or business

FATHER
12. Name: Charles B. Willson
13. Birthplace: Emmittsburg, Maryland

MOTHER
14. Maiden name: Julia A. Welty
15. Birthplace: Emmittsburg, Maryland

16. Informant: Richard Willson
Address: Hagerstown, Maryland

17. Entombment (Burial, cremation, or removal. Which?) Date thereof 4-27-45 (month) (day) (year)
Cemetery or crematory: Rose Hill Mausoleum
Location: Hagerstown, Maryland

18. Funeral director: C. M. Suter & Sons
Address: Hagerstown, Maryland

19. Apr. 26 1945 (Date rec'd by registrar) Elizabeth Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 24 1945 at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1930 to Apr 24 1945 and that I last saw h... alive on Apr 24 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	3 weeks
Due to: Hypertension	10 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: B. Lyn Thom M. D. or other
Address: Hagerstown, Md. Date signed 4/27/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Young

04291

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (K3-5)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 week

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 1 Week

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 25½ West Franklin St

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Mary Ellen Boyer-Wittkofsky

3.(b) Social Security Number: 214-09-5023

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife: John

6.(c) If alive, give age: 35 years

7. Birth date of deceased (mo., day, yr.): October 29 1911

8. AGE: Years	Months	Days	If less than one day
33	5	15	..... hrs. ..... min.

9. Birthplace: Ellerton Montgomery Co. Ohio (Town, county, and state)

10. Usual occupation: Sheet Metal Worker

11. Industry or business: Fairchild Corp.

FATHER — 12. Name: Charles E. Boyer

FATHER — 13. Birthplace: St. James Md.

MOTHER — 14. Maiden name: Eva E. Patten

MOTHER — 15. Birthplace: Ellerton Ohio

16. Informant: Carl W. Guessford Jr.

Address: Hagerstown Md.

17. n Burial (Burial, cremation, or removal. Which?) Date thereof 4/18/45 (month) (day) (year)

Cemetery or crematory: Ellerton Cemetery

Location: Miamisburg Ohio

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19. April 18 1945 (Date rec'd by registrar) Elast H Beavers Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH: April 16 1945 19..... at 5.15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Bichloride of mercury poisoning	7 days
Due to: acute glomerular nephritis	5 days
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: NO

Date of op. .....

Autopsy results: NO

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of Apr/10'45

Where did injury occur? Hagerstown (City or town) Wash. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury: Swallowed Bichlo... Injured at work? No

23. SIGNATURE: L. Robert Wells DEPUTY MEDICAL EXAM. WASH. CO., MD. M. D.

Address: Hagerstown, Md. Date signed: 4/18/45


RECEIVED
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04292

CERTIFICATE OF DEATH

Reg. Dist. No. 3021

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
330 Mitchell Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 330 Mitchell Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Alice G. Wolfe

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: John W. Wolfe

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feby. 10, 1887

8. AGE: Years	Months	Days	If less than one day
58	2	12	hrs. min.

9. Birthplace: Franklin County, Penn.
(Town, county, and state)

10. Usual occupation: Home Duties

11. Industry or business

FATHER
12. Name: Arthur Seville
13. Birthplace: Franklin County, Pa.

MOTHER
14. Maiden name: Sarah Mummert
15. Birthplace: Franklin County, Pa.

16. Informant: Mrs. Edna Knox-330 Mitchell Ave.
Address: 330 Mitchell Ave.- Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 24, 1945 (month) (day) (year)

Cemetery or crematory: River View Cemetery

Location: Williamsport, Md.

18. Funeral director: Fred W. Kraiss

Address: Hagerstown, Md.

19. April 24 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 22, 1945 4:40 a.m. p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 37 to Apr/22'45 19 19

and that I last saw her alive on Apr/21'45 19

Immediate cause of death	DURATION
cerebral paresis (syphilitic)	4yrs
Due to chr. myocarditis	6 yrs
Due to Embolism of lungs & brain	7 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: no

Date of op.

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. Robt. Wells, M.D.

M. D.

Address: Hagerstown, Md. Date signed: 4/23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Earl Young

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04293

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Mos
Hospital, Institution, or street address where death occurred:
825 Georgia Ave
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 825 Georgia Ave
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME Mrs Ester Mae Benner YOUNG

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife Paul
6.(c) If alive, give age 38 years
7. Birth date of deceased (mo., day, yr.) March 7 1908

8. AGE: Years	Months	Days	If less than one day
37	1	20	hrs. min.

9. Birthplace Hagerstown Wash. Co. Md.
(Town, county, and state)
10. Usual occupation Maid
11. Industry or business Dagmar Hotel
FATHER 12. Name Jacob S. Benner
13. Birthplace Thurmont Md.
MOTHER 14. Maiden name May Carnes
15. Birthplace Thurmont Md.
16. Informant Mrs. Brandt Bowers
Address Hagerstown Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/30/45 (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Hagerstown Md.
18. Funeral director Andrew K. Coffman
Address Hagerstown Md.
19. April 30 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1945 19 at 10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/1/45 19 to 4/27/45 19
and that I last saw her alive on 4/10/45 19

Immediate cause of death	DURATION
Coronary Thrombosis	1 hr.
Due to	
Due to	
Other conditions Marked obesity.	20 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Chas. H. Young M.D. M. D. or other
Address Hagerstown, Md. Date signed 4/28/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (111-a)

CERTIFICATE OF DEATH

04294

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington County.

City or town: Hagerstown Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 days

Hospital, institution, or street address where death occurred:
Washington County Hospital

How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Sharpsburg Maryland (If outside city or town limits, write RURAL and give nearest town)

Street No. Sharpsburg Maryland (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Lucy V. Zimmerman

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Frank Zimmerman deceased

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 5 1875

8. AGE: Years	Months	Days	If less than one day
69	9	14	..... hrs. ..... min.

9. Birthplace: Shepherdstown W. Va. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Samuel Badger
13. Birthplace: Shepherdstown W. Va

MOTHER
14. Maiden name: Mary McGacque
15. Birthplace: Shepherdstown W. Va.

16. Informant: Nannie Muck
Address: Johnstown, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 22 1945 (month) (day) (year)

Cemetery or crematory: Luthern Cemetery

Location: Sharpsburg Maryland

18. Funeral director: Edith V Leaf

Address: #7 Church St. Williamsport, Md.

19. Apr. 21 19 45 Chas. H. Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19 19 45, at 9-45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 19 45 to 4/19 19 45
and that I last saw her alive on 4/18 19 45

Immediate cause of death	DURATION
Pulmonary Embolism	instant.
Due to Saddle thrombus Abd. Aorta	7 wks.
Due to Mycotic Aneurism with Auricular fibrillation	?
Other conditions Gangrene Left leg	1 month

(Include pregnancy within 3 months of death)

Major findings of operations: Perforated ulcer
Left leg - Amputation Date of op. Apr. 16, 1945

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Walter H. Sheely M.D.
M. D. or other

Address: Sharpsburg, Md. Date signed 4/20/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING